BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
WILLEM H. KHOE, M.D. Certificate No. A-15719	NO. D-2750
Respondent	

ORDER DELAYING DECISION

Pursuant to section 11517(d) of the Government Code, the Division of Medical Quality, finding that a further delay is required by special circumstances, hereby issues this order delaying the decision for no more than 30 days from May 11, 1983 (when the 100-day period expires) to June 10, 1983.

The reasons for the delay are as follows: This case is on the agenda for discussion and decision at the next regularly scheduled meeting of the Division of Medical Quality, set for May 19, 1983, which is eight days after the expiration of the 100-day period on May 11, 1983. Therefore, the Division needs additional time to meet and complete its work in this case, including time after the meeting to draft and type the appropriate pleading, and to effect service on the parties.

DATED: 4/25/83

Lawrence Hill, MD

LARRY HILL, M.D.
President
Division of Medical Quality

REDACTED

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: WILLEM H. KHOE, M.D. Physician's and Surgeon's Certificate No. A-15719 3880 So. Jones Blvd., Ste. 214 Las Vegas, Nevada 89103 Respondent.	No. D-2750 L-24525

DECISION

A Proposed Decision in this case was originally non-adopted by the Division of Medical Quality. The Division then proceeded to decide the case itself upon the record, including the transcript. The parties were afforded the opportunity to present both oral and written argument before the Division itself.

Having considered the record and the arguments presented, the Division hereby adopts the Proposed Decision of the Administrative Law Judge to dismiss the accusation as its decision in this case.

In doing so, the Division, however, wishes to note its disagreement with the statements on page 4 of the Proposed Decision implying that patient harm is an indispensable element and must be shown before gross negligence or incompetence can be established.

The effective date of this Decision is April 2, 1984.

SO ORDERED March 2, 1984.

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

By
MILLER MEDEARIS
Secretary-Treasurer

FL:my

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

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STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
	No. D-2750
WILLEM H. KHOE, M.D. Physician and Surgeon's Certificate No. A-15719 3880 So. Jones Blvd., Ste. 214 Las Vegas, Nevada 89103,	L-24525
Respondent.	

PROPOSED DECISION

This matter originally came on to be heard before P. M. Hogan, Administrative Law Judge of the Office of Administrative Hearings sitting with a Panel of the Medical Quality Review Committee for District 11, consisting of Richard Gillman, M.D., Ann Richardson, L.V.N., and Rachel H. Gallegos, public member. Due to the length of the hearings, the Panel members requested to be discharged, and their request was granted. The matter was heard in its totality by the said Administrative Law Judge at Los Angeles, California commencing on December 4, 1981 and through December 10, 1981. Thereafter, the matter was continued to May 19, 1982 and continued from day to day thereafter until the taking of evidence concluded on May 28, 1982. Oral arguments were heard on July 10, 1982.

Complainant was represented by Robert McKim Bell, Deputy Attorney General. Respondent appeared personally and was represented by G.T.S. Khalsa, attorney at law.

The matter having been regularly submitted for decision, the Administrative Law Judge makes his findings of fact as follows:

I

Robert G. Rowland, complainant, filed the accusation herein solely in his official capacity as Executive Director of the Board of Medical Quality Assurance of the State of California.

II

On June 30, 1954, Willem H. Khoe, M.D. was issued physician and surgeon's certificate number A-15719; the certificate is currently in full force and effect.

III

The parties have timely filed and served all pleadings, notices and other papers as required by law. Jurisdiction for these proceedings exists.

RESPONDENT'S BACKGROUND

IV

Respondent is a [redacted] year old physician. A native of Indonesia, he completed his first year of medical school at the University of Indonesia at Jakarta. His education was interrupted by the war-time Japanese occupation.

He arrived in the United States in 1947, and took two years of pre-medical studies at La Sierra College, Loma Linda. He completed his medical training at Loma Linda University in 1953.

After a period of time at White Memorial Hospital, in 1955 respondent moved to Sun Valley Hospital (now Serra Memorial Hospital) in the Pocoima area. From that time until 1972, respondent was busy in a general family practice. In the latter part of this period, he came to specialize in abdominal surgery, and was, at one time, Chief of Staff of Serra Memorial Hospital.

V

Respondent first became curious about acupuncture in 1972 when he saw a televised program demonstrating acupuncture anaesthesia on a patient undergoing abdominal

surgery. Initially, he was quite skeptical of acupuncture, characterizing it as "voodoo medicine." However, he began to study the art, completing at least one hundred thirty-five hours of study at the University of Southern California. He did further study in Tokyo and at USC and UCLA. Finally, in 1974, he restricted his practice solely to acupuncture, seeing 25 to 30 patients, and working from 8:30 a.m. to 6:00 p.m. daily.

VI

Since 1974, in addition to his practice, respondent has lectured extensively at the behest of the World Health Organization. He has trained other physicians in acupuncture techniques, allowing them to accompany him in his office practice. He also has functioned as an examiner in acupuncture for the Board of Medical Quality Assurance.

VII

Since June of 1980, respondent has been working in Las Vegas under a Nevada reciprocity license. However, in 1979 and in the first half of 1980, he was engaged with a group of physicians at Sun Valley, California doing business as Serra Medical Group. Respondent worked in a suite which contained a waiting room and eight examination rooms. He employed one registered nurse and several nurse's aides. The nurse checked the patients for allergies, weighed them and took blood pressures. It was the custom of the office to record only positive findings in the office records. Respondent ordinarily took a brief history and physical exam at the same time. As noted, only the patient's complaint and positive findings would be recorded. However, respondent did always record the acupuncture points treated.

THE CHARGES

VIII

During the period 1979-80 respondent limited his practice to acupuncture and nutrition. Specifically, he treated only chronic, non-acute patients. If he was aware of gross pathology, or if the case were acute, he would refer the patient to another doctor.

IX

It has not been established by clear and convincing evidence to a reasonable certainty that respondent, in his

care and acupuncture treatment of the three patients described in the accusation, committed acts constituting gross negligence, or incompetence or repeated similar acts of negligence. In so concluding, the following facts, which are found to have been established, have been considered:

A. No appreciable harm was done to the three patient witnesses, nor was it clearly established that any one of the three was placed in significant risk of harm.

B. No evidence was presented as to the standard of record-keeping required of acupuncturists in Southern California during the relevant time period. While it may be respondent did not adhere to standards of history-taking, physical examination and record keeping usual and customary in "Western" or aleopathic medicine, such becomes irrelevant when the practitioner strictly confines himself to the practice of acupuncture.

C. Little credible evidence was presented as to the actual histories furnished and examinations performed by two of the three patient-witnesses; in one instance the witness bore great hostility toward the respondent and had pursued his complaint in an extravagant fashion; in the other instance, the patient witness obviously was uncertain in her recollection of the incident.

D. In light of the foregoing finding, the basis for expert opinion or the quality of respondent's care was shaky, and thus the reliability of such opinion is diminished. Moreover, there is manifestly insufficient evidence to establish any pattern, whether good, bad or indifferent, of respondent's practice.

E. In the absence of any showing of actual harm or significant risk of harm to patients, respondent's use of new techniques in acupuncture do not, without more, evidence incompetence or negligence.

X

Acupuncture is an art for which there is little objective scientific knowledge. Indeed, most, if not all, of the evidence as to its efficacy is entirely anecdotal. It is effective in pain-relief for many people. Regrettably, there are those who make patently extravagant claims and thereby subject the practice to charges of quackery. Respondent has unfortunately been associated with one such claimant, and this association has placed him vulnerable to such charge. However, it is not the function of the board to find him guilty by association. It should be kept in mind that this

9,000 year old art is being seriously studied in reputable universities.

XI

Finally, it should be noted that this 61 year old physician has been in the active practice of medicine for twenty-nine years with no history of disciplinary action. There is no evidence of civil or criminal claims against him.

XII

All charges contained within the accusation upon which no specific findings have been made have not been proved.

* * * * *

Pursuant to the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

It has not been established by clear and convincing evidence to a reasonable certainty that cause for discipline of respondent's certificate exists to Sections 2220 and 2234 (formerly Sections 2360 and 2361) of the Business and Professions Code by reason of the facts set forth above.

* * * * *

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The accusation is dismissed.

I hereby submit the foregoing which constitutes my Proposed Decision in the above-entitled matter, as a result of the hearing had before me on said dates, at Los Angeles, California, and recommend its adoption as the decision of the Board of Medical Quality Assurance.

DATED: Jan. 28, 1983

P. M. HOGAN
Administrative Law Judge
Office of Administrative Hearings

PMH:bbt

REDACTED

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: WILLEM H. KHOE, M.D. Physician's and Surgeon's Certificate No. A-15719, Respondent.	No. D-2750 ACCUSATION

Complainant alleges:

1. Robert G. Rowland is the Executive Director of the Board of Medical Quality Assurance of the State of California and brings this accusation solely in his official capacity.

2. On or about June 30, 1954, respondent Willem H. Khoe, M.D. (hereinafter "respondent") was issued physician's and surgeon's certificate number A-15719, which certificate is currently in full force and effect.

3. Pursuant to section 2004 (formerly § 2100.6) of the Business and Professions Code (hereinafter the "code"), the Division of Medical Quality is charged with the responsibility

for the administration and carrying out of disciplinary action appropriate to findings made by itself, a medical quality review committee, or a hearing officer.

4. Pursuant to sections 2220 and 2234 (formerly §§ 2360 and 2361) of the code, the Division of Medical Quality shall take action against any holder of a physician's and surgeon's certificate who is guilty of unprofessional conduct.

5. At all times pertinent to the allegations herein made, section 2234 (formerly § 2361) of the code provided that unprofessional conduct includes gross negligence, incompetence and repeated similar negligent acts.

6. The respondent is subject to disciplinary action for unprofessional conduct as defined in section 2234 of the code in that he is guilty of gross negligence, incompetence and repeated similar negligent acts. The circumstances surrounding these violations are as follows:

A. Patient Ben H.

On or about June 22, 1979, respondent undertook the medical care of one Ben H. (hereinafter referred to as "Ben"), a male patient, who had come to the respondent's office on that date seeking medical treatment and complaining that he was tired and cranky and was "not himself." Ben also told the doctor that he thought he might have hypoglycemia.

The respondent saw Ben and treated him on five occasions: June 22, July 11, August 1, 13, and 22, 1979.

On the first visit, Dr. Khoe treated and/or examined Ben with a device known as a "Dermatron" which, according to Dr. Khoe, tested "energy meridians in the fingers." The respondent told Ben that his examination indicated virus in the heart, allergic reaction to past bee stings, hypoglycemia, adrenal exhaustion and that his intestines were "a wreck."

The respondent prescribed and, over the remaining patient visits, commenced treatment with homeopathic medicines, electrical acupuncture, vitamin therapy and diet.

During an office visit on August 1, 1979, Ben complained to the respondent of excruciating lower back pain. The respondent replied that the pain was probably due to the patient's weightlifting exercises.

The respondent committed acts and omissions constituting gross negligence, incompetence and repeated similar negligent acts in his evaluation, diagnosis, treatment, medication, monitoring, record keeping, advice, care and handling of Ben including, but not limited to, the following:

The examinations and tests performed by the respondent on Ben, including his use of the Dermatron device, were insufficient and inadequate to establish a medically reliable finding of heart disease, allergic reaction, low blood sugar, adrenal exhaustion and intestinal disease, or to

diagnose Ben's other initial complaints.

Despite the diagnosis by the respondent of several serious or potentially life-threatening conditions, he failed to conduct any further standard diagnostic tests to confirm or refine his initial diagnostic findings or to monitor Ben's progress.

Treatment which followed the initial diagnosis, including vitamin therapy, was ineffective and not reasonably designed to care for the patient's diagnosed ailments or to relieve the patient's discomfort.

The failure by the respondent to specifically examine, or to record on his medical record, or to perform relevant diagnostic tests for the excruciating lower back pain complained of by the patient on August 1, 1979, was an extreme departure from existing standards of medical practice.

B. Patient Adrian C.

On or about July 9, 1979, respondent undertook the medical care of one Adrian C. (hereinafter referred to as "Adrian"), a female patient, who had come to the respondent's office seeking medical treatment and complaining that she experienced problems with elimination and headaches.

The respondent saw Adrian only once, on July 9, 1979.

Dr. Khoe examined Adrian by use of the Dermatron device and by palpating her abdominal area. He told Adrian that his examination indicated an open ileocecal valve and adhesions of the appendix.

Dr. Khoe treated Adrian with electrical acupuncture and by injecting her abdomen with vitamin B-12. The patient reacted with discomfort and swelling in her abdomen, muscle spasm, dizziness and headaches. When informed of her complaints the following day, the respondent recommended discontinuance of acupuncture and the application of ice to her abdomen.

The respondent committed acts and omissions constituting gross negligence, incompetence and repeated similar negligent acts in his evaluation, diagnosis, treatment, medication, monitoring, record keeping, advice, care and handling of Adrian including, but not necessarily limited to, the following:

No adequate medical history or physical examination was taken or conducted.

The respondent diagnosed a nonexistent condition, "open ileocecal valve," as a cause of the patient's complaint. There is no medical basis for such a diagnosis.

The respondent's examination of the patient was insufficient to exclude some other, perhaps more serious, cause for the patient's constipation, such as a colon cancer.

It is not possible by physical examination techniques to determine that tenderness in the abdomen is due to the ileocecal valve or to some other adjacent structure, nor is it possible to determine appendix adhesions by physical examination.

The use of the Dermatron device in examination or treatment of the patient was not of any accepted medical value in the diagnosis of disease in general nor of the patient's specific complaints, and it was not proper for this to influence or to be used to support the respondent's diagnosis.

There was no medical basis for the injection of vitamin B-12 in this patient and its use needlessly exposed her to risk.

C. Patient "Floyd P[redacted]"

On or about January 4, 1980, respondent undertook the medical care of one Floyd P[redacted], also known as Lloyd P. G[redacted] (hereinafter referred to as "Floyd") who complained of headaches and pain from a chipped spinal disc injured in a motorcycle accident.

The respondent saw Floyd and treated him only once, on January 4, 1980.

Dr. Khoe examined Floyd by having him remove his shirt and by examining his lower jaw. The respondent told Floyd that his examination indicated that his pain was not from a chipped disc but from the cutting off of energy flows. Dr. Khoe advised the patient not to wear

metal, such as a metal watch strap, as this would cut off energy flow.

Dr. Khoe treated Floyd by manipulating his lower jaw, by providing acupuncture, by giving him six injections of vitamin B-12 on both sides of his spinal column, and by prescribing a diet.

The respondent committed acts and omissions constituting gross negligence, incompetence and repeated similar negligent acts in his evaluation, diagnosis, treatment, medication, monitoring, record keeping, advice, care and handling of Floyd including, but not necessarily limited to, the following:

No adequate medical history or physical examination was taken or conducted.

No standard medical diagnostic techniques were directed toward the determination of the origin of the patient's back pain.

There is no accepted medical basis for the respondent's advice to the patient to avoid wearing metal on his body as an aid to energy flow.

There was no medical basis from the examination and history of the patient for the doctor to inject vitamin B-12 into the patient's back and its use needlessly exposed him to risk.

WHEREFORE, the complainant prays that the Division of Medical Quality hold a hearing on the matters alleged herein and, following said hearing, take such disciplinary

action against the respondent as is provided for in section 2227 of the code, or take such other and further action as may be proper.

Dated: May 21, 1981

Robert G. Rowland
Executive Director
Board of Medical Quality Assurance
State of California

Complainant

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